



DIVISION OF DEVELOPMENTAL DISABILITIES
Olympia, Washington

TITLE:	MORTALITY REVIEWS	POLICY 7.05
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Authority: Chapter 71A RCW

Reference: DSHS Administrative Policy 9.01, *Incident Reporting*
DSHS Administrative Policy 9.03, *Administrative Review - Deaths of Residential Clients*
DDD Policy 9.10, *Client Autopsy*
DDD Policy 12.01, *Incident Management*

PURPOSE

This policy establishes guidelines for the systematic review of the deaths of individuals served by agencies under state contract or funding with the Division of Developmental Disabilities (DDD). These reviews are intended to assist in identifying reasonable medical, educational, social, legal, or psychological intervention, which might have lessened the likelihood of the death occurring at that time. A “reasonable” intervention is one that would have been possible given known circumstances and resources available.

SCOPE

This policy applies to division staff.

POLICY

DDD shall establish a consistent process for review of all deaths of individuals supported by the division, as defined in the *Procedures* section of this policy, in an effort to:

- Identify factors that may have contributed to the deaths; and
- Recommend measures to improve supports and services for all persons served by DDD.

PROCEDURES**A. Deaths of Individuals Residing in Residential Habilitation Centers (RHC)**

1. The RHCs follow the procedures and requirements of DSHS Administrative Policy 9.03, *Administrative Review - Deaths of Residential Clients*.
2. The RHC sends a copy of the death report to the Central Office Incident Management Program Manager (IMPM) upon completion.

B. Deaths of individuals **not residing in licensed or certified homes or facilities, or whose deaths did not occur while going to, engaging in, or returning from employment, day program, or child developmental services:**

1. The Case Resource Manager (CRM) files an incident report immediately upon notification of the death through the DDD Incident Reporting Database, and updates it as new information becomes available;
2. The Central Office IMPM obtains a copy of the death certificate and forwards it to the CRM for inclusion in the deceased's file.
3. If the death was unusual or unexplained, refer to section D of this policy;
4. If the death occurs when an individual is in the care of a paid individual service provider (e.g., a Medicaid Personal Care shared living arrangement or respite care), the CRM shall consult with the Field Services Administrator to determine whether additional follow up is warranted.

C. Deaths of individuals who resided in licensed or certified homes or facilities or companion homes, or whose deaths occurred while going to, engaging in, or returning from employment, day program, or child developmental services:

1. The responsible agency/facility/provider immediately notifies the DDD regional office via phone or pager, and files an incident report within 24 hours of the time of death.
2. The CRM originates the incident report immediately via the DDD Incident Reporting System, updates the report as new information becomes available after the first 24 hours, and forwards all information to the Central Office IMPM.
3. The agency/facility/provider completes *Part 1: Provider Report* of the DDD *Mortality Review* form (DSHS 10-331) and forwards to the CRM within fourteen (14) calendar days of the death.

4. Upon receipt of the provider's report, the CRM completes *Part 2: Case Resource Manager Report* (DSHS 10-331A) and forwards it to the Regional Quality Assurance Program Manager (QAPM) within 14 calendar days of receipt of the *Provider Report*.
 5. The Regional QAPM reviews *Parts 1 and 2*, completes *Part 3: Quality Assurance Report*, (DSHS 10-331B) and forwards the report to the Central Office IMPM within 14 calendar days of receipt of *Part 2: Case Resource Manager Report*.
- D. If an unusual or unexplained death occurs, the Region will assemble a "mortality review team" to conduct an additional internal fact-finding review and make recommendations for follow-up action, as appropriate.
1. Unusual or unexplained deaths may be identified from the completed incident report, mortality review, media or legislative interest, and/or requests from the division director, family, agency, or provider.
 2. The fact-finding review shall address issues in three areas: a) policy and procedures; b) clinical support practice; and c) medical practice. Specific personnel issues must be addressed separately.
 3. The regional mortality review team shall review its preliminary draft with the Assistant Attorney General.
 4. Upon completion, the regional review team forwards its report and recommendations to the Central Office IMPM.
 5. If the regional mortality review team makes recommendations based upon its findings, the Regional Administrator or designee must develop an action plan, a copy of which must be sent to the Central Office IMPM.
- E. Central Office Mortality Review Team
1. For further review of deaths described in Section B above and in all cases where an additional review was conducted due to unusual or unexplained circumstances, the Division Director shall appoint a Mortality Review Team (MRT) to review the information gathered by the regions and submitted to Central Office. The team shall include the following members:
 - Quality Assurance/Self-directed Services Office Chief
 - Clinical Practices Manager
 - Community Residential Services Program Manager
 - Incident Management Program Manager

- Mental Health Professional
- Registered Nurse or Physician

2. In conducting its work, the MRT will:

- Order and review the official death certificate, and send a copy to the region;
- Review the Mortality Review Reports submitted by the regions;
- Review data from the Incident Reporting System and identify any trends and/or patterns that emerge;
- Review adherence to all applicable division and department policies;
- Report its findings to the Division Director at least quarterly;
- Make recommendations to the division director concerning needed training, policy changes, and other related issues; and
- Submit an annual report to DDD executive management.

3. Within 60 calendar days of receipt of the regional mortality review report, the MRT completes *Part 4: Central Office Review* (DSHS 10-331C) and forwards copies to the Division Director, the applicable region, and the provider.

SUPERSESSSION

None

Approved: /s/ Linda Rolfe
Director, Division of Developmental Disabilities

Date: 8/11/2003